EXHIBIT D

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

IN RE: UBER TECHNOLOGIES, INC. PASSENGER SEXUAL ASSAULT LITIGATION	MDL No. 3084 CRB **PLAINTIFF FACT SHEET**
This Document Relates to: ALL ACTIONS	

PLAINTIFF FACT SHEET

CASE NUMBER: _____

PLAINTIFF NAME: _____
on behalf of (if applicable): _____
relationship (if applicable): _____

GENERAL INSTRUCTIONS

Pursuant to the Order Regarding Fact Sheet Implementation entered in the above-captioned litigation, a completed Plaintiff Fact Sheet ("PFS") shall be provided for each individual asserting legal claims in the above captioned lawsuit. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please explain that in the response to the question and include the diligent efforts you have made to obtain the information. **Please do not leave any questions unanswered or blank.**

Additional Space for Completeness

In filling out any section or sub-section of this form, additional sheets of paper should be used and submitted as necessary to provide complete and accurate information.

Accuracy and Supplementation

The Plaintiff completing this Plaintiff Fact Sheet is under oath and must provide information that is true and correct to the best of her or his knowledge, information, and belief. Plaintiff is under an obligation to supplement these responses consistent with the Federal Rules of Civil Procedure.

DEFINITIONS

The following definitions shall apply to this PFS:

"You" and "Your" refers to the Plaintiff, listed above, who is completing this fact sheet, as well as her/his/their agents, representatives, and all other natural persons or entities acting on her/his behalf; provided that if the Plaintiff has filed this lawsuit on behalf of another (e.g., a decedent or a minor), then "You" and "Your" refers to the person on whose behalf this lawsuit was filed. In such a case, the Plaintiff should identify at the top of this page the person on whose behalf the case was filed and the Plaintiff's relationship to that person (e.g., guardian, administrator of estate, etc.).

"Driver" refers to the person who Plaintiff alleges, in the complaint filed in this action, committed sexual misconduct or assault against You.

"Incident" refers to all events that Plaintiff alleges, in the complaint filed in this action, constituted sexual misconduct or assault against You.

"Trip" refers to any ride that You, or another person on Your behalf or for Your benefit, requested through the rider version of the Uber Application around the time of the Incident.

"Health Care Provider" means any facility or person involved in the evaluation, diagnosis, care, or treatment of You, including without limitation any such hospital; clinic; medical center; physician's office; infirmary; medical or diagnostic laboratory; pharmacy; counselor; x-ray department; physical therapy department; rehabilitation specialist; physician; psychiatrist; physical therapist; osteopath; homeopath; chiropractor; psychologist; occupational therapist; nurse; herbalist; emergency responder including EMT, paramedic, or firefighter; social worker; or other facility or person that provides medical, dietary, psychiatric, mental, emotional, or psychological evaluation, diagnosis, care, treatment, or advice. This definition also includes professionals and facilities that may have treated, examined, evaluated, diagnosed, or otherwise cared for You as part of a Sexual Assault Response Team exam, a Sexual Assault Forensic Exam, or a Sexual Assault Nurse Exam.

CASE INFORMATION

1. Please state the following for the civil action that Plaintiff filed:

   a. Case number: _____

   b. Pseudonym used in the Complaint: _____

   c. Name of principal attorney representing Plaintiff: _____
   _____

YOUR PERSONAL INFORMATION

2. Name (Last, First, Middle): _____

3. Maiden name (if applicable) or other names used and dates You used those names: _____
   _____

4. Current address: _____

5. City and state of residence at time of Incident: _____

6. Date of birth: _____

7. From two years prior to the Incident through the present, please identify the employers for whom You worked; Your job title; Your responsibilities or duties; as well as the city, state, and dates of employment for each employer (use additional pages as necessary):

Employer No. 1

i. Name of Employer: _____
ii. Location of Employer (city, state): _____
iii. Dates of Employment: _____
iv. Job Title: _____
v. Responsibilities or Duties: _____

Employer No. 2

i. Name of Employer: _____
ii. Location of Employer (city, state): _____
iii. Dates of Employment: _____
iv. Job Title: _____
v. Responsibilities or Duties: _____

8. Check the box for the highest level of education You attained:

- ☐ Some High School
- ☐ High School Graduate/GED
- ☐ Some College
- ☐ Bachelor's Degree
- ☐ Associate Degree
- ☐ Master/Doctorate/Postgraduate Degree
- ☐ Other: _____

INFORMATION AS TO THE INCIDENT

9. Date of the Incident (Please provide the day, month, and year. If You do not recall the day, month, and year, please provide as much information as You can remember): _____

_____

10. State the name, phone number, and email address associated with the Uber account through which the ride at issue was arranged, if known:

a. Name (last, first, middle): _____

b. Phone Number: _____

c. Email Address: _____

11. State the location (including, city, state, zip, and nearest street address or, if unknown, the closest intersection) where the Trip originated: _____

_____

12. State the location (including, city, state, zip, and nearest street address or, if unknown, the closest intersection) of the requested destination for the Trip: _____

_____

13. Did the Driver take You to the requested destination for the Trip? Yes: ☐ No: ☐

14. Did the Driver take You to the requested destination for the Trip via a route other than the one suggested in the Uber Application? Yes: ☐ No: ☐

a. If *yes*, why did the Driver take You via an alternate route, if known? _____

_____

b. If *yes*, did You and the Driver discuss taking an alternate route before the Driver did so? Yes: ☐ No: ☐

c. If You and the Driver did discuss taking an alternate route before the Driver did so, please describe that discussion here: _____

_____

15. Did the Driver make any stops or pull over, other than at the requested destination for the Trip? Yes: ☐ No: ☐

a. If *yes*, where did the Driver stop or pull over, if known? _____

b. If *yes*, why did the Driver stop or pull over, if known? _____

c. If *yes*, did You and the Driver discuss stopping or pulling over before the Driver did so? Yes: ☐ No: ☐

d. If You and the Driver did discuss stopping or pulling over at a location other than the requested destination, please describe that discussion here: _____

_____

16. Did the Driver end the Trip at a location other than the requested destination? Yes: ☐ No: ☐

a. If *yes*, where did the Driver end the Trip, if known? _____

b. If *yes*, why did the Driver end the Trip at a location other than the requested destination, if known? _____

c. If *yes*, did You and the Driver discuss ending the Trip at a location other than the requested destination before the Driver did so? Yes: ☐ No: ☐

d. If You and the Driver did discuss ending the Trip at a location other than the requested destination, please describe that discussion here: _____

_____

17. State the time and location (including, city, state, zip, and nearest street address or, if unknown, the closest intersection) of the Incident: _____

_____

18. Were You inside the vehicle when the incident occurred? Yes: ☐ No: ☐

a. If *yes*, were You in the front or back seat? Front: ☐ Back: ☐

THE INCIDENT

19. Please describe the Incident in Your own words (attach additional sheets as needed): _____

_____

_____

_____

_____

_____

_____

_____

_____

20. If You know the first or last name of the Driver (or both), please state them: _____

_____

21. Did the Incident occur while the Driver was driving You to the requested destination for the Trip? Yes: ☐ No: ☐

a. If *no*, did the Incident occur before You entered or after you exited the Driver's vehicle?

Before entering the Driver's vehicle: ☐

After exiting the Driver's vehicle: ☐

b. If *no*, please state the approximate date(s) and time(s) the Incident occurred: _____

_____

c. If You would like to further explain or clarify Your answer(s) to this question, please do so here: _____

_____

22. Which of the following acts occurred during the Incident? Please select all that apply and where relevant select whether contact was over or under clothing:

- ☐ Lewd and/or Inappropriate Comments or Questions or Gestures[1]
- ☐ Verbal Threat of Sexual Assault[2]
- ☐ Masturbation and/or Indecent Exposure[3]
- ☐ Attempted Touching of a Non-Sexual Body Part[4]
  - ☐ Over the Clothes[5]
  - ☐ Under the Clothes[6]
- ☐ Attempted Kissing of a Non-Sexual Body Part[7]
- ☐ Attempted Touching of a Sexual Body Part Not Involving Penetration[8]
  - ☐ Over the Clothes
  - ☐ Under the Clothes

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[1] This category is defined to include, but is not limited to, the following: asking specific, probing, and personal questions of the user; making uncomfortable comments on the user's appearance; making sexually suggestive gestures at the user; and asking for a kiss, displays of nudity, sex, or contact with a sexual body part.

[2] This category is defined to include directing verbal explicit/direct threats of sexual violence at a user.

[3] This category is defined to include exposing genitalia and/or engaging in sexual acts in the presence of a user.

[4] This category is defined to include, without consent from the user, attempting to touch, but failing to come into contact with, any non-sexual body part (hand, leg, thigh) of the user.

[5] This category is defined to include any attempted touch over any piece of clothing on the user (e.g., pants, shirt, bra, underwear) as well as any attempted touch on an area that in no way has clothing covering it (e.g., parts of the thigh when wearing shorts).

[6] This category is defined to include any attempted touch on a part of a user's body which is covered by clothing. It does not include an attempted touch on an area that does not have clothing covering it in the first instance (e.g., parts of the thigh when wearing shorts).

[7] This category is defined to include, without consent from the user, attempting but failing to kiss, lick, or bite any non-sexual body part (e.g., hand, leg, thigh) of the user.

[8] This category is defined to include, without explicit consent from the user, attempting to touch, but failing to come into contact with, any sexual body part (i.e., breast, genitalia, mouth, buttocks) of the user. It does not include attempts at penetration.

- ☐ Attempted Kissing of a Sexual Body Part[9]
- ☐ Touching of a Non-Sexual Body Part[10]
  - ☐ Over the Clothes[11]
  - ☐ Under the Clothes[12]
- ☐ Kissing of a Non-Sexual Body Part[13]
- ☐ Attempted Sexual Penetration Including Oral Copulation[14]
- ☐ Touching of a Sexual Body Part Not Involving Penetration[15]
  - ☐ Over the Clothes
  - ☐ Under the Clothes
- ☐ Kissing of a Sexual Body Part[16]

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[9] This category is defined to include, without consent from the user, attempting but failing to kiss, lick, or bite on either the breast or buttocks of the user. This also includes attempts to kiss on the lips and attempts to kiss while using tongue.

[10] This category is defined to include, without explicit consent from the user, touching or forcing a touch on any non-sexual body part (e.g., hand, leg, thigh) of the user.

[11] This category is defined to include any touch over any piece of clothing on the user (e.g., pants, shirt, bra, underwear) as well as any touch on an area that in no way has clothing covering it (e.g., parts of the thigh when wearing shorts).

[12] This category is defined to include any touch under clothing which causes contact with the user's skin. It does not include a touch on an area that does not have clothing covering it in the first instance (e.g., parts of the thigh when wearing shorts).

[13] This category is defined to include, without consent from the user, any kiss, lick, or bite, or forced kiss, lick, or bite on any non-sexual body part (e.g., hand, leg, thigh) of the user.

[14] This category is defined to include, without explicit consent from a user, attempting but failing to penetrate, no matter how slight, the vagina or anus of a user with any body part or object. This includes attempted penetration of the user's mouth with a sexual organ or sexual body part. This excludes kissing and attempted kissing with tongue.

[15] This category is defined to include, without explicit consent from the user, touching or forcing a touch on any sexual body part (i.e., breast, genitalia, mouth, buttocks) of the user. It does not include penetration.

[16] This category is defined to include, without consent from the user, any kiss, lick, or bite, or forced kiss, lick, or bite on either the breast or buttocks of the user. This also includes kissing on the lips and kissing while using tongue.

☐ Sexual Penetration Including Oral Copulation[17]

☐ Kidnapping[18]

☐ Other. If *other*, please describe: _____

WITNESSES

23. Was there another passenger in the vehicle with You at the time of the Incident? Yes: ☐ No: ☐

a. If *yes*, please identify the other passenger(s) by name, full address and phone number, if known: _____

_____

_____

b. If *yes*, did You know the other passenger(s) before You or someone on Your behalf requested the Trip? Yes: ☐ No: ☐

24. To Your knowledge, did anyone besides You and the Driver hear, see, or otherwise witness the Incident at the time it occurred? Yes: ☐ No: ☐

a. If *yes*, state the name, address and telephone number, if known, of all such witnesses to the Incident: _____

_____

_____

25. Did You or someone on Your behalf notify any of the following entities of the Incident (Please check all that apply): Uber: ☐ Law Enforcement: ☐ Healthcare Professional (non-therapist/counselor/psychiatrist/psychologist): ☐ Therapist/Counselor/Psychiatrist/Psychologist: ☐

[17] This category is defined to include, without explicit consent from a user, penetration, no matter how slight, of the vagina or anus of a user with any body part or object. This includes penetration of the user's mouth with a sexual organ or sexual body part. This excludes kissing with tongue.

[18] This category is defined to include abduction, child abduction, false imprisonment, human trafficking, unlawful restraint, and unlawful/forcible detention.

26. If You or someone on Your behalf notified Uber, please answer the following questions:

a. When did You or someone on Your behalf notify Uber of the Incident? _____

_____

b. How did You or someone on Your behalf notify Uber? Phone Call: ☐ Email: ☐ In-App Notification: ☐ Other: ☐. If *other*, please describe: _____

_____

c. If someone notified Uber on Your behalf, state that person's name, address, and phone number, if known: _____

_____

27. If You or someone on Your behalf notified law enforcement, please answer the following questions:

a. When did You or someone on Your behalf notify law enforcement of the Incident? ___

_____

b. If someone notified law enforcement on Your behalf, state that person's name, address, and phone number, if known: _____

_____

c. To Your knowledge, list all law enforcement agencies that were notified about the Incident: _____

_____

d. To Your knowledge, list the names of all law enforcement agent(s) You or someone on Your behalf have communicated with about the Incident: _____

_____

e. Please state whether You appeared for any criminal hearing(s) or trial(s) and if so, in what courthouse(s) and on what date(s): _____

_____

28. If You or someone on Your behalf notified a healthcare professional (non-therapist/counselor/psychiatrist/psychologist), please answer the following questions:

a. When did You or someone on Your behalf notify a healthcare professional of the Incident? _____

b. If someone notified a healthcare professional on Your behalf, state that person's name, address, and phone number, if known: _____

_____

c. To Your knowledge, list the names of all healthcare professionals You or someone on Your behalf have communicated with about the Incident: _____

_____

29. If you or someone on Your behalf notified a therapist/counselor/psychiatrist/psychologist, please answer the following questions:

a. When did You or someone on Your behalf notify a therapist/counselor/psychiatrist/psychologist of the Incident? _____

_____

b. If someone notified a therapist/counselor/psychiatrist/psychologist on Your behalf, state that person's name, address, and phone number, if known: _____

_____

c. To Your knowledge, list the names of all therapist/counselor/psychiatrist/psychologist(s) You or someone on Your behalf have communicated with about the Incident: _____

_____

30. Have You spoken to any of the following about the Incident (Please check all that apply): Spouse: ☐ Romantic Partner (unmarried): ☐ Family Member: ☐ Friend: ☐ Other: ☐

a. If You checked any of the above boxes, please identify the names of the individuals You have spoken to about the Incident: _____

_____

_____

_____

_____

31. Have You posted information regarding the Incident on a website or on social media (e.g., a social media site, a blog, a personal website, etc.), including anonymously? Yes: ☐ No: ☐

a. If *yes*, list all such websites or social media, and where applicable, specify the username/account handle You used to make the post: _____

_____

_____

_____

_____

_____

INJURIES AND DAMAGES

32. Did You suffer mental or emotional harm caused in whole or in part by the Incident? Yes: ☐ No: ☐

a. If *yes*, please use the chart below to identify the mental or emotional injury/injuries, illness(es), or condition(s) You allege were caused in whole or in part by the Incident.

Injury, Illness, or Condition	Check all that apply	Approximate date of onset	Is it ongoing? [Y / N]
Anxiety			
Obsessive-Compulsive Disorder (OCD)			
Eating Disorder			
Changes in Appetite or Weight			
Panic Attacks			
Post-Traumatic Stress Disorder (PTSD)			
Serious Phobias (Including Social Anxiety, Claustrophobia, Agoraphobia, etc.)			
Depression			
Feelings of Hopelessness			
Difficulty Falling Asleep or Disrupted Sleep			
Fatigue			
Poor Concentration			
Mood Swings			
Irritability			
Anger/Outbursts			
Addiction and Related Substance Abuse Problems			
Suicidal Thoughts			
Death by Suicide			
Other (Specify): _____			

b. If You would like to further describe, explain, or clarify the mental or emotional harm You allege You have suffered in whole or in part as a result of the Incident, please do so here: _____

33. Did You suffer physical harm caused in whole or in part by the Incident? Yes: ☐ No: ☐

a. If *yes*, please describe: _____

34. Were You treated by emergency responders, including police officers, EMT, fire fighters, or paramedics, as a result of the Incident? Yes: ☐ No: ☐

35. Have You ever been treated by any Health Care Provider, including counselors or therapists, other than emergency responders for any injury that You allege was caused in whole or in part by the Incident? Yes: ☐ No: ☐

36. Have You been diagnosed with any physical, mental, emotional, or other medical condition by a Health Care Provider that You allege was caused in whole or in part by the Incident? Yes: ☐ No: ☐

a. If *yes*, identify the following for each condition:

Condition Number 1

Health Care Provider Name: _____

Health Care Provider Facility (if applicable): _____

Approximate Date of Diagnosis: _____

Condition Number 2

Health Care Provider Name: _____

Health Care Provider Facility (if applicable): _____

Approximate Date of Diagnosis: _____

37. Did You undergo a medical exam to determine any physical injuries or the presence of any evidence (e.g., a Sexual Assault Response Team "SART" exam, a Sexual Assault Forensic Exam ("SAFE"), or a Sexual Assault Nurse Exam ("SANE"))? Yes: ☐ No: ☐

If You answered yes to Question 34, 35, 36, or 37, state the name, address, and telephone number for each Health Care Provider who has diagnosed, treated, or examined You for injuries that You allege were caused in whole or in part by the Incident; the diagnosis, treatment, or examination received, including emergency care if applicable; and the date(s) of diagnosis, treatment, or examination. Please provide both the name of the facility where the diagnosis, treatment, or exam occurred and the name of the person(s) who issued or administered the diagnosis, treatment, or examination, if known. As discovery is ongoing, You must supplement this form if and when You are treated by additional providers.

Name, Address, Telephone Number of Health Care Provider	Diagnosis, Treatment, or Examination	Date(s) of Diagnosis, Treatment, or Examination

38. Do You claim or expect to claim that You lost earnings or suffered impairment of earning capacity as a result of any physical, mental, or emotional injury You allege? Yes: ☐ No: ☐

a. If *yes*, please describe Your claim and the amount of damages You are claiming or expect to claim for this category of loss, if known. If applicable, please list Your wages before and after the Incident: _____

_____

_____

_____

_____

If You answered yes to Question 38, ***You must complete Exhibit D—Authorization to Disclose Employment Records.***

39. Do You seek or expect to seek to recover any out-of-pocket costs, including medical expenses covered by insurance, that You have incurred relating to the diagnoses and/or treatment of any physical, mental, or emotional injuries You allege You sustained as a result of the Incident? Yes: ☐ No: ☐

a. If *yes*, please list any out-of-pocket costs that You allege You have incurred as a result of the Incident. As discovery is ongoing, please update as expenses accrue.

Category and/or Types of Expenses Incurred (e.g., co-pay, deductibles, prescriptions, etc.)	Approximate Amount of Out-of-Pocket Costs

PRIOR CLAIMS AND LEGAL MATTERS

40. Have You ever filed a workers' compensation claim? Yes: ☐ No: ☐

a. If *yes*, please describe the nature of the lawsuit and where You filed the lawsuit, if known: _____

_____

_____

_____

_____

41. Have You ever filed a claim for Social Security Disability Insurance benefits ("SSDI")? Yes: ☐ No: ☐

a. If *yes*, please describe the nature of the lawsuit and where You filed the lawsuit, if known: _____

_____

_____

_____

_____

42. Have You ever filed any other lawsuit? Yes: ☐ No: ☐

a. If *yes*, please describe the nature of the lawsuit and where You filed the lawsuit, if known: _____

_____

_____

_____

_____

PERSONS LIKELY TO HAVE DISCOVERABLE INFORMATION ON WHICH PLAINTIFF MAY RELY

To the extent that anyone not already listed above is known by You to likely have discoverable information, please state the name and, if known, current location (city, state) of each individual—along with the general subject(s) of that information, excluding the Plaintiff, the Driver, and any past or present employees of Uber. Please include, without limitation, all witnesses to the Incident and all persons with whom Plaintiff has spoken about the Incident, excluding Plaintiff's attorneys. To the extent that You do not know the name of any of the witnesses, for such witnesses, please provide any identifying information that You are aware of (e.g., neighbor, coworker, bystander).

Name, Address, Telephone Number	Subjects

AUTHORIZATIONS

Plaintiff agrees to produce copies of signed and dated authorizations for the releases listed below. Plaintiff agrees that this PFS shall not be considered complete unless and until signed authorization forms are submitted. Plaintiff agrees that any document request for records to be produced by Plaintiff will not preclude Defendant from also collecting such records directly from the source pursuant to the signed authorizations.

Attach the following documents to this PFS, making certain that all releases are signed and dated:

1) Limited Authorization to Disclose Health Information (Ex. A)—leave the "To" field blank.
2) Authorization to Disclose Psychiatric, Psychotherapy, and Mental Health Information (Ex. B)—leave the "To" field blank.
3) Authorization to Disclose Law Enforcement Records (Ex. C)—leave the "To" field blank.
4) If You answered *yes* to Question 38, execute the Authorization to Disclose Employment Records (Ex. D)—leave the "To" field blank.

VERIFICATION

I, _____, hereby state that I have reviewed the Plaintiff Fact Sheet. The statements set forth therein are true and correct to the best of my knowledge, information, and belief. I make this verification based on my personal knowledge. I also declare that I have completed and submitted all required authorizations listed above. I declare under penalty of perjury that the foregoing is true and correct. I understand that I am under an obligation to supplement these responses.

Executed on the ____ day of _____, 2024.

_____

Exhibit A

(Limited Authorization to Disclose Health Information)

AUTHORIZED IN CONNECTION WITH

IN RE: UBER TECHNOLOGIES, INC., PASSENGER SEXUAL ASSAULT LITIGATION
Northern District of California
No. 3:23-md-3084-CRB

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"))

TO: _____
(Health Care Provider)

Please complete all sections of this release form below. Please leave the "To" field above blank.

Patient's Name: _____

Former/Alias/Maiden Name of Patient: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Patient's Address: _____

I, _____, hereby authorize any Health Care Provider,[1] including the one listed above, to disclose and furnish to Uber Technologies, Inc. ("Uber") and/or _____

[1] "Health Care Provider" means any facility or person involved in the evaluation, diagnosis, care, or treatment of You, including without limitation any such hospital; clinic; medical center; physician's office; infirmary; medical or diagnostic laboratory; pharmacy; counselor; x-ray department; physical therapy department; rehabilitation specialist; physician; psychiatrist; physical therapist; osteopath; homeopath; chiropractor; psychologist; occupational therapist; nurse; herbalist; emergency responder including EMT, paramedic, or firefighter; social worker; or other facility or person that provides medical, dietary, psychiatric, mental, emotional, or psychological evaluation, diagnosis, care, treatment, or advice. This definition also includes professionals and facilities that may have treated, examined, evaluated, diagnosed, or otherwise

its duly assigned agents, including Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss") and its attorneys, employees, and agents, the protected medical and/or insurance information listed below for the purpose of review and evaluation in connection with a legal claim.

I. Health Information to Be Disclosed

Disclose any and all protected medical and/or insurance information and records. For the purposes of this authorization "medical and/or insurance information and records" shall be given the broadest definition allowed under applicable federal and state law, including but not limited to:

- Records of inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, phone notes, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and letters or records received by other physicians.

- All laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram, and catheterization reports, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

- All pharmacy/prescription records, including NOC numbers and drug information handouts/monographs.

- All billing records, including all statements, itemized bills, and insurance records.

- All records of any samples of prescription medicines provided.

- All employment or insurance records, including all disability records, social security records, Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claim or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other related documents.

- All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

- **Notwithstanding the broad scope of the above disclosure requests, this authorization form does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis, including psychotherapy notes, as such terms are defined by HIPAA, 45 CFR § 164.501.**

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cared for You as part of a Sexual Assault Response Team exam, a Sexual Assault Forensic Exam, or a Sexual Assault Nurse Exam.

I expressly request that any Health Care Provider identified above disclose full and complete protected medical information. I authorize disclosure of the above-specified information to Paul, Weiss and to its attorneys, employees, and agents, who have agreed to pay reasonable charges incurred by the Health Care Provider to supply copies of such records.

1. To the Health Care Provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to treatment for alcohol, drug, and other substance abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Care Provider at the Health Care Provider's address. I understand the revocation will not apply to information that has already been released in response to this authorization. Cancellation, revocation, or modification will be valid only once the Health Care Provider receives written notification of such cancellation, revocation, or modification. A copy of said notification shall also be sent to Paul, Weiss. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits.

5. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524.

6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including HIPAA. If I have questions about disclosure of my health information, I can contact the Health Care Provider.

7. A notarized signature is not required. 45 CFR § 164.508. A copy of this authorization may be used in place of an original.

II. Form of Disclosure

____ An electronic record
____ Hard copy

III. Duration of Authorization

This authorization shall be effective until January 1, 2028, or until the conclusion of my case in *In re: Uber Technologies, Inc., Passenger Sexual Assault Litigation*, 3:23-md-03084-CRB (MDL No. 3084), whichever date is later in time.

IV. Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such a legal guardian or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe how this person has legal authority to sign this form:

_____

Exhibit B

(Authorization to Disclose Psychiatric, Psychotherapy, and Mental Health Information)

AUTHORIZED IN CONNECTION WITH

IN RE: UBER TECHNOLOGIES, INC., PASSENGER SEXUAL ASSAULT LITIGATION
Northern District of California
No. 3:23-md-3084-CRB

AUTHORIZATION TO DISCLOSE PSYCHIATRIC, PSYCHOTHERAPY, AND MENTAL HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"))

TO: _____
(Health Care Provider)

Please complete all sections of this release form below. Please leave the "To" field above blank.

Patient's Name: _____

Former/Alias/Maiden Name of Patient: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Patient's Address: _____

I, _____, hereby authorize any Health Care Provider,[1] including the one listed above, to disclose and furnish to Uber Technologies, Inc. ("Uber") and/or _____

[1] "Health Care Provider" means any facility or person involved in the evaluation, diagnosis, care, or treatment of You, including without limitation any such hospital; clinic; medical center; physician's office; infirmary; medical or diagnostic laboratory; pharmacy; counselor; x-ray department; physical therapy department; rehabilitation specialist; physician; psychiatrist; physical therapist; osteopath; homeopath; chiropractor; psychologist; occupational therapist; nurse; herbalist; emergency responder including EMT, paramedic, or firefighter; social worker; or other facility or person that provides medical, dietary, psychiatric, mental, emotional, or psychological evaluation, diagnosis, care, treatment, or advice. This definition also includes

its duly assigned agents, including Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss") and its attorneys, employees, and agents, the protected medical and/or insurance information listed below for the purpose of review and evaluation in connection with a legal claim.

I. Health Information to Be Disclosed

Disclose any and all psychiatric, psychotherapy, and mental health records, notes, and information. For the purposes of this authorization "psychiatric, psychotherapy, and mental health records, notes, and information" shall be given the broadest definition allowed under applicable federal and state law, including but not limited to:

> Complete copies of all psychotherapy notes as defined by 45 CFR § 164.501, psychiatric records and psychotherapy notes reports, therapist's notes, social worker's records, all medical records, physicians' records, surgeons' records, pathology/cytology reports, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, correspondence, insurance records, consent for treatment, statements of account, itemized bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of this patient, or documents containing information regarding amendment of protected health information in the medical records. This listing is not meant to be exclusive.

I expressly request that any Health Care Provider identified above disclose full and complete protected medical information. I authorize disclosure of the above-specified information to Paul, Weiss and to its attorneys, employees, and agents, who have agreed to pay reasonable charges incurred by the Health Care Provider to supply copies of such records.

1. To the Health Care Provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

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professionals and facilities that may have treated, examined, evaluated, diagnosed, or otherwise cared for You as part of a Sexual Assault Response Team exam, a Sexual Assault Forensic Exam, or a Sexual Assault Nurse Exam.

2. I understand that the information in my health record may include information relating to treatment for alcohol, drug, and other substance abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Care Provider at the Health Care Provider's address. I understand the revocation will not apply to information that has already been released in response to this authorization. Cancellation, revocation, or modification will be valid only once the Health Care Provider receives written notification of such cancellation, revocation, or modification. A copy of said notification shall also be sent to Paul, Weiss. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits.

5. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524.

6. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including HIPAA. If I have questions about disclosure of my health information, I can contact the Health Care Provider.

7. A notarized signature is not required. 45 CFR § 164.508. A copy of this authorization may be used in place of an original.

II. Form of Disclosure

____ An electronic record
____ Hard copy

III. Duration of Authorization

This authorization shall be effective until January 1, 2028, or until the conclusion of my case in *In re: Uber Technologies, Inc., Passenger Sexual Assault Litigation*, 3:23-md-03084-CRB (MDL No. 3084), whichever date is later in time.

IV. Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such a legal guardian or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe how this person has legal authority to sign this form:

_____

Exhibit C

(Authorization to Disclose Law Enforcement Records)

AUTHORIZED IN CONNECTION WITH

IN RE: UBER TECHNOLOGIES, INC., PASSENGER SEXUAL ASSAULT LITIGATION
Northern District of California
No. 3:23-md-3084-CRB

AUTHORIZATION TO DISCLOSE LAW ENFORCEMENT RECORDS

TO: _____
(Law Enforcement Agency)

Please complete all sections of this release form below. Please leave the "To" field above blank.

Plaintiff's Name: _____

Former/Alias/Maiden Name of Plaintiff: _____

Plaintiff's Date of Birth: _____

Plaintiff's Social Security Number: _____

Plaintiff's Address: _____

I, _____, hereby authorize any Law Enforcement Agency, including the one listed above, to disclose and furnish to Uber Technologies, Inc. ("Uber") and/or its duly assigned agents, including Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss") and its attorneys, employees, and agents, the information listed below for the purpose of review and evaluation in connection with a legal claim.

I. Information to Be Disclosed

Disclose any and all law enforcement records related to the report I or someone on my behalf made regarding all the events that I allege constituted sexual misconduct or assault against me.

For the purposes of this authorization "law enforcement records" shall be given the broadest definition allowed under applicable federal and state law, including but not limited to intake forms, interview notes and recordings, crime scene reports, witness reports, case management documents, criminal complaints, and legal filings. This listing is not meant to be exclusive.

I expressly request that any Law Enforcement Agency identified above disclose full and complete protected information. I authorize disclosure of the above-specified information to Paul, Weiss and to its attorneys, employees, and agents, who have agreed to pay reasonable charges incurred by the Law Enforcement Agency to supply copies of such records.

II. Form of Disclosure

____ An electronic record or access through an online portal

____ Hard copy

III. Duration of Authorization

This authorization shall be effective until January 1, 2028, or until the conclusion of my case in *In re: Uber Technologies, Inc., Passenger Sexual Assault Litigation*, 3:23-md-03084-CRB (MDL No. 3084), whichever date is later in time.

IV. Acknowledgement

I understand that the information used or disclosed pursuant to this authorization carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

V. Revocation

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Law Enforcement Agency at the Law Enforcement Agency's address. I understand the revocation will not apply to information that has already been released in response to this authorization. Cancellation, revocation, or modification will be valid only once the Law Enforcement Agency receives written notification of such cancellation, revocation, or modification. A copy of said notification shall also be sent to Paul, Weiss.

VI. Copies

A photocopy of this authorization is to be considered as valid as the original.

VII. Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such a legal guardian or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe how this person has legal authority to sign this form:

_____

Exhibit D

(Authorization to Disclose Employment Records)

AUTHORIZED IN CONNECTION WITH

IN RE: UBER TECHNOLOGIES, INC., PASSENGER SEXUAL ASSAULT LITIGATION
Northern District of California
No. 3:23-md-3084-CRB

AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS

TO: _____
(Employer)

Please complete all sections of this release form below. Please leave the "To" field above blank.

Plaintiff's Name: _____

Former/Alias/Maiden Name of Plaintiff: _____

Plaintiff's Date of Birth: _____

Plaintiff's Social Security Number: _____

Plaintiff's Address: _____

I, _____, hereby authorize the Employer listed above to disclose and furnish to Uber Technologies, Inc. ("Uber") and/or its duly assigned agents, including Paul, Weiss, Rifkind, Wharton & Garrison LLP ("Paul, Weiss") and its attorneys, employees, and agents, the information listed below for the purpose of review and evaluation in connection with a legal claim.

I. Information to Be Disclosed

Disclose any and all records relating to my employment, including any medical information protected by the Health Insurance Portability and Accountability Act ("HIPAA"), from the day I turned eighteen (18) years old to the present or for ten (10) years prior to the date on which this authorization is signed to the present, whichever period is longer in time.

For the purposes of this authorization "records related to my employment" shall be given the broadest definition allowed under applicable federal and state law, including but not limited to all records and information pertaining to my personnel file, copies of all applications for employment, claims for unemployment benefits, resumes, records of all positions held, job descriptions of

positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2s and W-4s, worker's compensation files, all health care records, including all hospital, physician, clinic, infirmary, nurse and dental records, x-rays, test results, physical examination records, any records pertaining to claims made relating to health, disability or accidents in which I was involved, including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the Employer or in my personnel file. This listing is not meant to be exclusive.

I expressly request that any Employer identified above disclose full and complete protected information. I authorize disclosure of the above-specified information to Paul, Weiss and to its attorneys, employees, and agents, who have agreed to pay reasonable charges incurred by the Employer to supply copies of such records.

II. Form of Disclosure

____ An electronic record or access through an online portal

____ Hard copy

III. Duration of Authorization

This authorization shall be effective until January 1, 2028, or until the conclusion of my case in *In re: Uber Technologies, Inc., Passenger Sexual Assault Litigation*, 3:23-md-03084-CRB (MDL No. 3084), whichever date is later in time.

IV. Acknowledgements

I understand that the information used or disclosed pursuant to this authorization carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including HIPAA. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524.

V. Revocation

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Employer at the Employer's address. I understand the revocation will not apply to information that has already been released in response to this authorization. Cancellation, revocation, or modification will be valid only once the Employer receives written notification of such cancellation, revocation, or modification. A copy of said notification shall also be sent to Paul, Weiss.

VI. Copies

A photocopy of this authorization is to be considered as valid as the original.

VII. Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such a legal guardian or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe how this person has legal authority to sign this form:

_____